ALABAMA HEALTH INFORMATION EXCHANGE

Alabama Strategic and Operational Plans For Health Information Exchange

State Health Information Exchange

Cooperative Agreement Program

June 2013 Update in Response to ONC-HIE-PIN-002

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CONTACT AND SUBMISSION INFORMATION

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Date of Submission to CMS Regional HITECH Point of Contact:	June 8, 2013

VERSION HISTORY

Version	Date Submitted	Notes
1	**November 30, 2011**	**Original Submission**
2	**February 17, 2012**	**Update**
3	**June 1, 2012**	**Update**
4	**July 10, 2012**	**Update**

TABLE OF CONTENTS

APPENDICES

Section 1: Alabama S/OPs Update Changes

Basic Requirements

Alabama's S/OPs Update follows the ONC-HIE-PIN-002 issued February 8, 2012, and due to ONC by June 8, 2013. This submission completes the requirement.

Responsibility for the Alabama Strategic and Operational Plans (A-S/OPs) and Alabama State Medicaid Health Information Plan (A-SMHP) is with the Alabama State Medicaid Agency (A-SMA), which assures ongoing coordination of design, development, implementation and coordination of all activities under the A-S/OPs. This A-S/OPs update aligns with the current A-SMHP.

A-HIE (One Health Record®) Strategy Changes

Alabama continues to make progress on implementing Health Information Exchange (HIE) services as anticipated within the Strategic Plan approved by ONC in November 2011 and A-S/OPS updates in 2012. Changes to the HIE Strategy provided in this document are only for those sections required by the Office of the National Coordinator (ONC), including sustainability, project management plan, privacy and security, and evaluation. They are included in the chart below and in the following sections.

The following chart identifies the proposed changes to Alabama S/OPs, the reason for the proposed changes, budget implications as currently identified, the domain sections where the changes occur as well the section location of the change. Alabama provided an update to the S/OPs in July 2012. The sections in the July S/OPs update match with those in this document; therefore each section of the July 2012 update is modernized through this submission.

Domain Sections	November 2011 Approved A-S/OP and 2012 Updates	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
Overall HIE Strategy including Phasing	1. Alabama's One Health Record® Health Information Exchange (A-HIE), Strategic and Operational Plan Update (June 2012, page 7) 2. Strategic and Operational Plan Details (June 2012, page 35) 2.1.3 2012 Specific Goals, Objectives and Strategies (June 2012, page 39) 2.2.4 Timelines (June 2012,	Alabama's Phase 1 to Phase 2 Strategy changes have been incorporated into this S/OP update.	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.

Domain Sections	November 2011 Approved A-S/OP and 2012 Updates	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
	page 48)_ 2.3.2 A-HIE Keys to Success (June 2012, page 51)			
Governance	2.5.1 Governance (June 2012, page 60)	N/A: Continuation under current and no change of governance prior to end of ONC Cooperative Agreement.		
Technology	2.5.3 Technical Infrastructure (June 2012, page 74)	Alabama's Phase 1 to Phase 2 Strategy changes have been incorporated into this S/OP update.	Phasing in changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Financial	2.5.2 Finance (June 2012, page 68)	N/A: Continuation under current and no change of prior to end of ONC Cooperative Agreement		ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Business Operations	Establishment of Financial and Business Plan (2010 - page 19) 2.5.4 Technical and Business Operations (June 2012, page 80)	N/A: Continuation under current plan and no changes of prior to the end of ONC Cooperative Agreement.		ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Legal/Policy	Use Agreements Created for HIE Participants (2010 - page 21) Privacy and Security (2012 – pages 29-33) 1.5.5 Policy and Legal (June 2012, page 29) 2.5.5 Policy and Legal (June 2012, page 84)	Alabama's Phase 1 to Phase 2 Strategy changes have been incorporated into this S/OP update.	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Strategies for e-Prescribing	1.4.2 Support for 3 High Priority Meaningful Use	N/A: No changes under this S/OPs update.		

Domain Sections	November 2011 Approved A-S/OP and 2012 Updates	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
	Requirements-E-prescribing (June 2012, page 13)			
Strategies for Structured Lab Results Exchange	1.4.2 Support for 3 High Priority Meaningful Use Requirements-Receipt of Structured Lab Results (June 2012, page 14)	N/A: No changes under this S/OPs update.		ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Strategies for Care Summary Exchange	1.4.2 Support for 3 High Priority Meaningful Use Requirements-Sharing of Patient Care Summaries (June 2012, page 14)	N/A: No changes under this S/OPs update.		ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Sustainability	1.5 Five Domains Plus One 2.5.2 Finance (June 2012, page 67) 2.5.4 Technical and Business Operations (June 2012, page 79) 2.9 Issues, Risks, Dependences and Proposed Mitigation of Risks (June 2012, page 133)	Sustainability Plan provided on following pages.	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Privacy and Security Framework	1.5.5 Policy and Legal (June 2012, page 29) 2.1.3 2012 Specific Goals, Objectives and Strategies (June 2012, page 39) 2.3.3 Strategic Imperatives (June 2012, page 54) 2.5.3 Technical Infrastructure (June 2012, page 73) 2.5.5 Policy and Legal (June 2012, page 83)	Privacy and Security Framework provided on following pages	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.
Evaluation Plan	2.6 Outcomes and Performance Measures for Operations and Evaluation	Evaluation Plan and Interim Report provided on the following pages and as	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate

Domain Sections	November 2011 Approved A-S/OP and 2012 Updates	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
	(June 2012, page 115)	an appendix		Medicaid funding for appropriate elements.
Project Management Plan	2. Strategic and Operational Plan Details (June 2012, page 36) 2.1.3 2012 Specific Goals, Objectives and Strategies (June 2012, page 39) 2.2.4 Timelines (June 2012, page 48)_ 2.3.2 A-HIE Keys to Success (June 2012, page 51)	Project Plan provided on the following pages.	Phasing in of changes as a result of Phase 2.	ONC Phase 2 funding and appropriate Medicaid funding for appropriate elements.

Section 2: Sustainability Plan

Alabama's sustainability plan, in compliance with PIN #ONC-HIE-PIN-001, released on July 6, 2010, is focused on sustaining a statewide safe, secure and user-friendly infrastructure with technical and business operations supports, legal and policy parameters and financial sustainability to ensure operations beyond the end of the ONC funding. As provided previously in Alabama's approved Phase 1 to Phase 2 Plan, the state and stakeholders have worked together to develop a phased-in strategy that evolves as the marketplace mature. Alabama has addressed short-term and longer- term financial sustainability as of a part of its Phase 1 to Phase 2 plan and ongoing operations. The Phase 1 to Phase 2 Plan is provided in Appendix A.

Current activities of the state to create and maintain demand for HIT and HIE services and provider adoption and use of electronic health records (EHRs) include:

(1) Continued state support of the Medicaid EHR Incentive Program through identification, attestation and payment to eligible Medicaid "meaningful use" (MU) providers;
(2) Continued coordination and alignment of the Medicare EHR Incentive Program through use of the Medicare audit functions for eligible hospitals (EHs) rather than duplicative state efforts;
(3) Coordination of efforts with the Alabama regional extension center (REC) related to potential eligible Medicaid "meaningful use" providers;
(4) Continued support of current One Health Record® technology (provided in chart in Appendix B)
(5) Addressed HIT efforts related to integration of acute, preventive and long term care services, as a part of Alabama's Medicaid Health Home State Plan.
(6) Development of a Data Analysis Division within A-SMA to define and specify consistent collection of data, analysis and reporting for adult Medicaid measures.
(7) Dedicated resource within the A-SMA HIT Division for fiscal and financial reporting regarding the HIT programs, which includes the State HIE grant, effective November 2012.

A-SMA is engaged in ongoing environmental assessments of hospital and provider health-IT efforts to assure the timing of the One Health Record® statewide phase in meets the needs of geographic areas. Providers, who are upgrading their EHRs from Stage 1 to Stage 2, are prioritizing their health-IT efforts and the state is seeking to align with the timing of their connectivity to One Health Record® to support their needs. A screenshot example from One Health Record® sign-in page follows.

The state as a part of its Phase 1 to Phase 2 Plan (Appendix A) has the authority to award one-time connectivity grants to providers to accelerate One Health Record® adoption. The one-time grants are designed to help qualifying provider entities purchase federally-certified products from "preferred" electronic health record (EHR) vendors. To qualify for these grants, the hospitals must have 60 or fewer beds and all applicants need to be located in rural areas where larger hospitals are already connected or expect to be connected within six months. Participating vendors must agree to a fair and fixed price and will be asked to match 25 percent of the system's cost in in-kind services. "Many of these providers are interested in participating in a robust, interoperable health information exchange," Parker said. "However, acquiring the necessary technology is a financial and logistical challenge for these organizations."

Medicaid Funding

Medicaid funding is a critical component of the state's short-term and longer-term sustainability plan. While a future HIT/HIE-I-APDU will be submitted for the Medicaid cost allocation for the operation of the One Health Record® when the public and private financial allocations for the ongoing operation are finalized, funding for staffing has already been approved through both the HIT/MU-I-APDU and the HIT/HIE I-APDU. The methodology currently under consideration for determining the appropriate cost allocation is as follows: insured population/total Alabama Population. It is estimated that Medicaid has approximately 950,000 enrollees and is expecting another 500,000 with the 2014 anticipated changes for approximately 33% of the insured population. Blue Cross Blue Shield of Alabama appears to have about 60% of the population, other state agencies about .2%, and other private carriers about 6.8%.

Section 3: Privacy and Security Framework

Privacy and Security Framework

The A-HIE, One Health Record® Legal and Policy Workgroup met on November 2, 2012, and addressed the current privacy and security framework domains. The first table addresses the domain, further detail on the domain and Alabama's approach, separated into, One Health Record's® obligations and each participant's obligations. A copy of the Alabama Privacy and Consent Notice effective December 2012 is also provided. The privacy and security framework and requirements are a part of the agreements that must be signed prior to "on-boarding" to One Health Record®. It is also included in the training to all participants.

Domain	Detail	Description of approach and where domain is addressed in policies and practices		Description of how stakeholders & public are made aware	Gap area
		One Health Record's® Obligations	Participant's Obligations		
Correction	Individuals should be provided with a timely means to dispute the accuracy or integrity of their individually identifiable health information and to have erroneous information corrected or to have a dispute documented if requests are denied	One Health Record® shall comply with all federal, state, and local laws, including but not limited to HIPAA and HITECH, as they pertain to PHI exchanged via the AHIE. One Health Record® shall make rules to ensure that Individuals are provided with a simple and timely means to access and obtain their PHI and PII in a readable form and format. One Health Record® shall make rules to ensure Individuals are provided with a timely means to dispute the accuracy or integrity of their PHI and PII and to have erroneous information corrected or to have a dispute documented if requests are denied	Participant must provide Individuals with a simple and timely means to access and obtain their PHI and PII in a readable form and format. Participant must provide Individuals with a timely means to dispute the accuracy or integrity of their PHI and PII within the Participant's records and to have erroneous information corrected or to have a dispute documented if requests for correction are denied.	The legal agreements governing Alabama's services, including One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	N/A
Individual Access and	Individuals should be provided with a simple and	At this time, One Health Record® does not permit granular choice. As		The legal agreements governing Alabama's services, including	Will be re-visited

Choice	timely means to access and obtain their individually identifiable health information in a readable form and format Individuals should be provided reasonable opportunity and capability to make informed decisions about the collection, use and disclosure of their IIHI. Individuals should be able to designate someone to make decisions on their behalf. Process should be fair and not burdensome.	technology improves, it may be added in the future. Also partly covered through opt out and notice, which is provided following this Table.		One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	when technology allows for more granularity of choice
Openness and Transparency	There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and their IIHI. Individuals "should" be able to determine what information exists about them, how it is collected, used or disclosed and whether they can exercise choice.	One Health Record® should make publicly available a notice of privacy and/or data practices describing why PHI is collected, how it is used, and to whom and for what reasons it is disclosed. One Health Record® shall make rules to ensure Individuals have the ability to request and review documentation to determine who accessed their information or to whom it has been disclosed.	Participants are encouraged to be open and transparent with their Individual patients about the Participant's privacy and security practices and to specifically discuss One Health Record® with those Individuals. Participants must provide Individuals with the ability to request and review documentation to determine who accessed their information or to whom it has been	The legal agreements governing Alabama's services, including One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	N/A

	Individuals "should" have the ability to request and review documentation to determine who accessed their information or to whom it has been disclosed.	.	disclosed. Each Participant shall develop, maintain, and distribute a notice of privacy and/or data practices that complies with HIPAA, HITECH, and any other applicable law. This notice (or other informational material delivered to Individuals) must advise Individuals why PHI is collected, how it is used, and to whom and for what reasons it is disclosed, and where public information on this topic can be obtained. Participant shall document disclosures to comply with HIPAA. Each Participant disclosing health information through AHIE shall implement a system to document such information as may be necessary for compliance with the HIPAA Privacy Rule's accounting of disclosures requirement. Each Participant is responsible for ensuring its compliance with such requirement and may choose to provide Individuals with more information in the accounting than is		

			required. Each requesting Participant must be able to provide information required for the disclosing Participant to meet its obligations under the HIPAA Privacy Rule's accounting of disclosures requirement. Participant shall maintain an access Audit Log. Participant shall maintain an audit log documenting who of Participant's employees and/or contractors posted and accessed the information about an Individual through AHIE and when such information was posted and accessed. Upon request, Participant shall provide patients with an accounting of who has posted and who has accessed information about them through One Health Record® and when such information was accessed, or alternatively, provide		

			Individual access to AHIE.		
Limitations on Collection, Use, and Disclosure	IIHI should be collected, used & disclosed only to extent necessary to accomplish a specific purpose and never to discriminate inappropriately.	One Health Record® shall make rules to ensure Individuals have the ability to request and review documentation to determine who accessed their information or to whom it has been disclosed. Participant shall document disclosures to comply with HIPAA. Each Participant disclosing health information through AHIE shall implement a system to document such information as may be necessary for compliance with the HIPAA Privacy Rule's accounting of disclosures requirement. Each Participant is responsible for ensuring its compliance with such requirement and may choose to provide Individuals with more information in the accounting than is required. Each requesting Participant must be able to provide information required for the disclosing Participant to meet its obligations under the HIPAA Privacy Rule's accounting of disclosures requirement. Participant shall maintain an access Audit Log. Participant shall maintain an audit log documenting who of Participant's employees and/or contractors posted and accessed the		The legal agreements governing Alabama's services, including One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	/A

		information about an Individual through AHIE and when such information was posted and accessed. Upon request, Participant shall provide patients with an accounting of who has posted and who has accessed information about them through One Health Record® and when such information was accessed, or alternatively, provide Individual access to			
Data Integrity	One Health Record® should take reasonable steps to ensure that IIHI is complete, accurate, and up to date to the extent necessary for intended purposes and has not been altered or destroyed in unauthorized manner.	One Health Record® is not responsible for verifying or correcting any information made available by Participant through One Health Record®. Also covered under current policies 5 and 7.	Each Participant is responsible for maintaining the quality and security of information entered into Participant's Electronic Medical Records (EMR) and made available to other Participants through One Health Record®. For instance, each Participant must ensure that data exchanged is complete and accurate; patients are correctly matched with their data; appropriate policies are in place to detect prevent, and mitigate unauthorized changes or deletions of PHI; and corrections are communicated in a timely manner to those with whom data has been exchanged	The legal agreements governing Alabama's services, including One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	N/A

Safeguards & Accountability	IIHI should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized access, use or disclosure. HIE should ensure appropriate monitoring mechanisms are in place to report and mitigate non-adherence to policies and breaches. Reasonable mitigation strategies should be established and implemented, including notice to individuals of privacy violations and security breaches	Covered under current policy number 9. Covered under current policy 8 and 9 and BAA.		The legal agreements governing Alabama's services, including One Health Record® Policies and Procedures, are posted publicly on the One Health Record®. The One Health Record® Commission and Commission work groups are public meetings. Notice of meetings and meeting materials are posted. Participants are trained as a part of the on-boarding process.	N/A

One Health Record ® Notice of Privacy and Data Practices

Following is the One Health Record® current Notice of Privacy and Data Practices, which will be provided to all patients. It must be signed and will be retained as part of the business operations.

NOTICE OF PRIVACY AND DATA PRACTICES

Effective: December 1, 2012

This notice describes how personal health information about you may be used and disclosed and how you can get access to this information.
Please review this notice carefully.

"The Practice" as defined herein:
Name:_____
Address:_____
_____
Number:_____

Notice Regarding Your Health Information

This Notice describes this Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, as well as all employees, staff, volunteers, contractors, and other Practice personnel. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. Your health care providers need all of your health information to accurately diagnose and treat you. Each of your providers may have different portions of your medical record. If they can access each other's records and see more complete health information, they can provide you with better care. Sharing your health information can also help reduce your costs by eliminating unnecessary duplication of tests and procedures.

Notice of Confidentiality of Your Health Information

Your health information is personal. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of our Notice of Privacy and Data Practices in effect at the time.

Notice of Use and Disclosure of Your Health Information

There are times when this Practice uses and discloses health information about you, as allowed by law, for a number of different purposes. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Right to Use and Disclose for Payment.** We may use and disclose health information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may disclose your record to an insurance company, so that we can get paid for treating you, or we may tell your health plan about a treatment you are going to receive in order to obtain necessary approval or to determine whether your plan will cover the treatment.

- **Right to Use and Disclose for Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

- **Right to Use and Disclose for Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical

students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

- **Right to Use and Disclose for Other Permitted Purposes.** Other ways we may use or disclose your protected healthcare information include for appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

Notice of Electronic Sharing of Your Health Information (OneHealthRecord)

Alabama has adopted a state-wide, internet-based, health information exchange called OneHealthRecord, whereby participating providers and health insurers can, through electronic means, see your health information in each other's records for the permitted uses disclosed above. Your participation in OneHealthRecord is voluntary; however, your health information will be included in OneHealthRecord, unless you "opt out" as explained below.

How is my privacy protected in this electronic health exchange? OneHealthRecord and the participating providers and health insurers use a combination of safeguards to protect your health information. Technical safeguards include encryption, password protection, and the ability to track every viewer's usage of the system. Administrative safeguards include written policies controlling access to information through OneHealthRecord. All participating providers and health insurers are also regulated by federal and state privacy laws.

Are there privacy risks in this electronic health exchange? Yes. Doctors, hospitals and anyone else who is treating you are already responsible for keeping your health records private. The only added risk is that your health record will now be seen through the computer rather than by mail or fax. There is always a risk that the safeguards will not work and that someone will obtain, view or use your health information for impermissible purposes. No system of safeguards is perfect. The participating providers and health insurers believe the potential benefits outweigh the risk, but your participation is a personal decision you must make for yourself.

Are there privacy risks in this electronic health exchange? Yes. Doctors, hospitals and anyone else who is treating you are already responsible for keeping your health records private. The only added risk is that your health record will now be seen through the computer rather than by mail or fax. There is always a risk that the safeguards will not work and that someone will obtain, view or use your health information for impermissible purposes. No system of safeguards is perfect. The participating providers and health insurers believe the potential benefits outweigh the risk, but your participation is a personal decision you must make for yourself.

Can I choose not to participate in this electronic health exchange? Yes. We call this a decision to "opt out". Your health information will not be available for sharing through OneHealthRecord. However, your name, address, gender, date of birth, and opt-out status will be available, and your doctors may be able to see your health information in their own electronic medical records. If you opt out, it may affect what information your provider has available when providing your care. Your decision to opt out of OneHealthRecord applies only to sharing your information through OneHealthRecord. It does not affect other sharing of health information between your providers or health insurers. Health care providers may use other electronic methods such as secure email or electronic lab results delivery to share patient information.

How do I opt out of OneHealthRecord? Complete and return the Opt-Out/Revoke Opt-Out Form to this Practice. This form can be obtained online or from this Practice. Whatever method you choose, your opt-out decision cannot be implemented until after you have had your first visit as a patient.

Can I hold back certain records I don't want my health insurer or other providers to see? Not at this time. All or none of your health information is made available through OneHealthRecord.

If I opt out, can I later change my mind? Yes. If you opt out, you may change your mind and revoke that choice by submitting the Opt-Out/Revoke Opt-Out Form. If you revoke your earlier decision to opt out, all of the information that has been gathered by participating providers and health insurers since you opted out will be available for sharing through OneHealthRecord.

Notice of Your Individual Rights Regarding Your Health Information

You have the following rights with respect to health information that we maintain about you:

- **Right to Request Restrictions.** You have the right, at any time, to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Even if we agree to a restriction, either you or we can later terminate the restriction.

- **Right to Receive Confidential Communications.** You have the right to request that we communicate health information about you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. You must make your request in writing and you must specify how or where you wish to be contacted. We will accommodate your request. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of health information about you. We may deny your request to inspect and copy in certain very limited circumstances. Requests must be submitted in writing to the Practice. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have this right for so long as the health information is maintained by us. To request an amendment, your request must be made in writing and submitted to the Practice and you must provide a reason that supports your request. We may deny your request for an amendment, and you also will have the right to complain about our denial of your request.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you within the last six years that have not been excluded by law from such accounting, such as disclosures made to you or authorized by you or to carry out treatment, payment and health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Practice with a stated time period for disclosures. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

- **Right to Copy of this Notice.** You have the right to a paper copy of this notice. You may ask the Practice to give you a copy of this notice at any time.

Notice of Your Individual Rights Regarding Your Health Information

You have the following rights with respect to health information that we maintain about you:

- **Right to Request Restrictions.** You have the right, at any time, to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Even if we agree to a restriction, either you or we can later terminate the restriction.

- **Right to Receive Confidential Communications.** You have the right to request that we communicate health information about you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. You must make your request in writing and you must specify how or where you wish to be contacted. We will accommodate your request. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of health information about you. We may deny your request to inspect and copy in certain very limited circumstances. Requests must be submitted in writing to the Practice. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have this right for so long as the health information is maintained by us. To request an amendment, your request must be made in writing and submitted to the Practice and you must provide a reason that supports your request. We may deny your request for an amendment, and you also will have the right to complain about our denial of your request.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you within the last six years that have not been excluded by law from such accounting, such as disclosures made to you or authorized by you or to carry out treatment, payment and health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Practice with a stated time period for disclosures. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

- **Right to Copy of this Notice.** You have the right to a paper copy of this notice. You may ask the Practice to give you a copy of this notice at any time.

Other Information

- **Our Right to Change Notice of Privacy Practices.** We reserve the right to change this Notice of Privacy and Data Practices. We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice.

- **Availability of Notice of Privacy Practices.** A hard copy of our current Notice of Privacy and Data Practices will be available upon request at our Practice locations, as well as posted on OneHealthRecord's web site: *http://onehealthrecord.alabama.gov*

- **Effective Date of Notice.** The effective date of the notice will be stated on the first page of the notice.

- **Complaints.** You may complain to us at the Practice and/or to the United States Secretary of Health and Human Services at Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201, if you believe your privacy rights have been violated by us. All complaints should be submitted in writing. You will not be retaliated against for filing a complaint.

- **Questions and Information.** If you have any questions or want more information concerning this Notice of Privacy and Data Practices or OneHealthRecord, please contact the Practice or visit the web site: *http://onehealthrecord.alabama.gov*.

ACKNOWLEDGEMENT

Please sign acknowledging that you have been informed about OneHealthRecord and have been advised that if you do not opt-out, your health information will be included in OneHealthRecord.

SIGNATURE: _____

DATE: _____

Section 4: Program Evaluation

Preliminary Evaluation Results

The Department of Health Care Organization and Policy (HCOP) in the School of Public Health at the University of Alabama at Birmingham (UAB) completed an objective evaluation of the performance of One Health Record® in April 2013 for the A-SMA. The interim evaluation report, provided in Appendix C, describes the process of starting up One Health Record® and its progress to date at becoming operational. A final report in the spring of 2014 will evaluate the achievements of the system.

Interim Report Data Sources

Interim Report Data Sources	
One Health Record® Technical and Technical and Business Operations, including Direct Secure Messaging	Interviewed the program manager of Truven, the contractor that is supplying and hosting the AHIE software platform
	Examined documents related to the plan for One Health Record®
	Structured interviews either by phone or in person with senior leadership at hospitals that are close to going live onto the system
	Interviewed physicians' practices and vendors who sell and service EHRs have been postponed
	Interviewed physicians' practices and vendors who sell and service EHRs have been postponed
e-Prescribing	Examined data from the SureScripts system to learn about the extent of e-prescribing
Laboratories	Examined the results of lab surveys commissioned by A-SMA to learn about the electronic exchange of information among clinical laboratories;
	Examined databases maintained by CDC. Interviewed physicians' practices and vendors who sell and service EHRs have been postponed
Interstate: Direct Messaging	Examined documents from Florida and Alabama.

Key Findings:

Area	Finding
One Health	A-SMA has successfully procured a software platform from Truven Health

Area	Finding
Record® Technical	Analytics for hosting the system. It has also acquired additional software for analyzing and creating reports on healthcare utilization, patient demographics and technical aspects of system utilization. In regard to what ONC has designated as Program Priority Area 3 (PPA3), the exchange of clinical information among providers, *One Health Record* as of the Spring 2013, has succeeded in loading essential data files that identify providers and patients and it has half a dozen hospitals in the final stages of exchanging test data with the system. 20 HIE readiness assessment submitted: 13 hospitals, 2 co health depts.., one local exchange organization, 1 psychiatric providers, 1 physician practice, 1 Medicaid District Office, ALPHCA
One Health Record® Implementation	The pace of implementation is several months behind its original plan and this slower pace appears to be due to the following: • Various providers have taken longer than expected to work out the rules in their own systems for sharing data with the AHIE. This has been especially complicated for hospitals in relation to affiliated physician practices. • Some EHR venders have been slow at developing connections between their products and the AHIE. Some of this slowness seems to be due to technical challenges and some to competing business priorities regarding software development. • Alabama, to its credit, elected to create a system that emphasized the exchange of structured data among all providers rather than FAX-like images of data. This decision has increased development time but should permit better integration and retrieval of longitudinal information in the system.
e-Prescribing	In regard to ONC's PPA, pharmacy participation in e-prescribing, steady progress has been made toward near universal participation. According to data provided by SureScripts, in 2012, 94% of Alabama pharmacies had activated e-prescribing and 68% of physicians were routing prescriptions electronically. Physician use of e-prescribing is expected to continue to grow because more physicians are moving to adopt EHRs partly in response to HITECH incentives.
Clinical Laboratory Electronic Exchange	In regard to ONC's PPA, laboratory participation in delivering electronically structured results, licensure records maintained by the Centers for Disease Control and Prevention (CDC) show that there are 161 hospital and 130 independent clinical laboratories in Alabama. A-SMA commissioned surveys of these laboratories in 2011 and 2012 to determine their

Area	Finding
	electronic information exchange capabilities. Both survey efforts had low response rates making it difficult to determine electronic capabilities throughout the state. One problem may be that the survey contractors were working with contact lists that were less comprehensive than the CDC's. Another problem is that individual laboratories may not have personnel who can knowledgeably respond to questions about the details of electronic information exchange, especially regarding formats such as LOINC or HL7. The CDC licenses distinct physical facilities but many of the independent labs are owned and operated by a national or regional company. A local lab manager may have a rough idea of how much test information is exchanged with providers via mail, courier, FAX or a computer link but exactly what protocols are used is knowledge that is more likely to reside at corporate headquarters. It should be noted that ONC has recently commissioned its national evaluation contractor NORC to conduct a statistically valid sample survey of 12,000 hospital and independent clinical laboratories.
Direct Secure Messaging	One Health Record® included a tool for provider-to-provider secure messaging in February of 2012. The Web portal featuring Direct Secure Messaging (DSM) or DIRECT exchange will facilitate the MU Stage II requirement among Alabama hospital and office-based providers for securely exchanging summary of care documents (Provider Priority Area 3) during transition of care or with referrals from one provider to another. Since the time that the DIRECT tool was first released, 400 Alabama providers have enrolled to participate (Medicaid, August 2012). The State has since launched a DIRECT recruitment campaign statewide. In particular, the DIRECT engagement efforts are currently targeting a pilot site in East, Alabama where Care Network of East AL, Inc., a 501-c organization, operates one of four active community-based networks in the State that support primary medical providers (PMPs) among Alabama Medicaid's Patient First eligibles. Providers who sign up for DIRECT follow a series of standard registration steps such as reviewing OHR policies and procedure documents and signing a participant agreement, a business agreement, and a qualified services organization agreement. Once enrolled the State team offers system administrators within practices a training on the web account and DSM as well as a site visit for follow-up to assist with any issues or concerns and to monitor progress using the Web portal.
Interstate Direct Messaging	In March 2013, The Florida Health Information Exchange announced that it had established Direct Secure Messaging Service with systems in Georgia and Alabama. Through this national standard connection, providers in each of the three states are able to send encrypted messages across state

Area	Finding
	lines to colleagues who have registered for the service in their respective states.

Tracking Progress

Consistent with and building on the PIN released on July 6, 2010 (#ONC-HIE-PIN-001), the state monitors and tracks key Meaningful Use HIE capabilities in the state. The following is the information from the Alabama CMS Annual Report updated April 30, 2013.

AIU and MU Summary

State/ Territory/ District:	AL
Program Year:	2012
Total number FQHCs that operate in your state	116

INSTRUCTIONS: Provide below the number of providers paid and the amount broken out by Adopt, Implement or Upgrade during the calendar year

Total Providers Paid (Adopt)	183	26	209
Total Paid Amount (Adopt)	3973750	14643577.9	18617327.9
Total Providers Paid (Implement)	105	12	117
Total Paid Amount (Implement)	2224167	15333095.31	17557262.31
Total Providers Paid (Upgrade)	115	6	121
Total Paid Amount (Upgrade)	2450835	2549374.92	5000209.92
Total Providers Paid (AIU)	403	44	447
Total Paid Amount (AIU)	8648752	32526048.13	41174800.13

How many unique FQHCs have been assigned a payment by at least one EP for AIU?	6

Provided below the number of providers and the numbers of practice locations by Provider type that were paid an incentive payment for AIU during the calendar year

Section 1.2: AIU Provider Types and Practices	
Provider Type	**Total Providers**
Physician	264
Nurse Practitioner	75
Dentist	53
Optometrist	
Certified Nurse Midwives	3
Pediatricians	6
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	2

Acute Care Hospital	44
Critical Access Hospital	
Children's Hospital	1
Total Number of locations with CEHRT which have been paid AIU	365

Provided below the number of providers paid and the amount paid for Meaningful User broken out by EP and EH during the calendar year

Section 1.3: MU Counts and Amounts	**EP**	**EH**	**Total**
Total Providers Paid (Meaningful Use)	120	3	123
Total Paid Amount (Meaningful Use)	1049750	1500487.32	2550237.32

How many unique FQHCs have been assigned a payment by at least one EP for MU?	1

INSTRUCTIONS: Provide below the number of providers and the numbers of practice locations by Provider type that were paid an incentive payment for MU during the calendar year

Section 1.4: MU Provider Types and Practices	
Provider Type	**Total Providers**
Physician	89
Nurse Practitioner	30
Dentist	
Optometrist	
Certified Nurse Midwives	1
Pediatricians	
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	
Acute Care Hospital	3
Critical Access Hospital	
Children's Hospital	
Total Number of locations with CEHRT which have been paid MU	57

Meaningful Use Core Measures Aggregate Data

State/ Territory/ District:	AL
Program Year:	2012

Section 2.1: MU Core Measures

Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	0.88526421	0.11652636			120	120
EPCMU 02 Drug Interaction Checks					120	0
EPCMU 03 Maintain Problem List	0.948414418	0.063099293			120	120
EPCMU 04 ePrescribing	**0.830697391**	**0.156024021**			120	120
EPCMU 05 Active Medication List	0.967538001	0.041340783			120	120
EPCMU 06 Medication Allergy List	0.961155338	0.088458938			120	120
EPCMU 07 Record Demographics	0.909208219	0.086176146			120	120
EPCMU 08 Record Vital Signs	0.930557233	0.095893578			120	120
EPCMU 09 Record Smoking Status	0.841768013	0.132835523			120	120
EPCMU 10 Clinical Quality Measures					120	0
EPCMU 11 Clinical Decision Support Rule					120	0
EPCMU 12 Electronic Copy of Health Information	0.992610837	0.039791858	91	0.758333	120	29
EPCMU 13 Clinical Summaries	0.838579367	0.155176851			120	120
EPCMU 14 Electronic Exchange of Clinical Information					120	0
EPCMU 15 Protect Electronic Health Information					120	0

Meaningful Use Menu Measures Aggregate Data

Section 2.2: MU Menu Measures

Menu Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			5	0.04902	21	0.170731707	102	0
EPMMU 02 Clinical Lab Test Results	0.914703434	0.143120162			27	0.219512195	96	96
EPMMU 03 Patient Lists					24	0.195121951	99	0
EPMMU 04 Patient Reminders	0.909090909				122	0.991869919	1	1
EPMMU 05 Patient Electronic Access	1	0	1	0.25	119	0.967479675	4	3
EPMMU 06 Patient-specific Education Resources	0.453203573	0.268095078			25	0.203252033	98	98
EPMMU 07 Medication Reconciliation	0.966317983	0.057965376	3	0.052632	66	0.536585366	57	54
EPMMU 08 Transition of Care Summary	0.978015734	0.08747195			107	0.869918699	16	16
EPMMU 09 Immunization Registries Data Submission			192	0.262295	30	0.243902439	93	0
EPMMU 10 Syndromic Surveillance Data Submission			102	0.515152	89	0.723577236	34	0

INSTRUCTIONS: Subject to §495.332, the State may propose a revised definition of meaningful use of certified EHR technology, subject to CMS prior approval, but only with respect to limited objectives. Please indicate if you were approved by CMS to revise the definition.

Select:	No

Core Clinical Quality Measure Aggregate Data

State/ Territory/ District:	AL
Program Year:	2012
Total Unduplicated Providers Reported:	120

Section 3.1: Core CQMs					
Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of providers who entered 0 in the denominator
CCQM 1 - NQF 0013 Hypertension: Blood Pressure Measurement	0.949147317	0.176733059			57
CCQM 2 - NQF 0028 a. Tobacco Use Assessment	0.823020141	0.249167017			11
CCQM 2 - NQF 0028 b. Tobacco Cessation Intervention	0.380669904	0.420464415			35
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 1)	0.394235546	0.21803575			39
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 2)	0.38024426	0.245687133			22

Alternate Clinical Quality Measure Aggregate Data

Section 3.2: Alternate CQMs					
Alternate Core					
Meaningful Use Measure	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 1	0.658076321	0.298665459			51
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population - 1 Numerator 2	0.204394734	0.27121494			51

ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 3	0.210455226	0.283139485			51	
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 1	**0.553144043**	**0.374775396**			**51**	
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 2	**0.103425145**	**0.181045668**			**51**	**# of providers who entered 0 in the denominator**
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 3	0.098183381	0.171938255			51	3
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 1	0.582230531	0.377516414			51	4
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 2	0.115073257	0.19370823			51	4
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 3	0.110506268	0.190273331			51	**3**
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 1	0.503437793	0.407882164			51	**4**
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 2	0.531676006	0.43493679			51	4

ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 3	0.590980269	0.359341803			51	3
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 4	0.53108924	0.433992744			51	4
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 5	0.507751856	0.415045506			51	4
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 6	0.602655446	0.345582623			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 7	0.498699862	0.410190557			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 8	0.343996275	0.299754712			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 9	0.505284506	0.411022892			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 10	0.100258296	0.176980728			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 11	0.38526639	0.368110434			51	5
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 12	0.372979109	0.357051452			51	5
ACCQM 3 - NQF 0041 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	0.057567926	0.110942238			38	5

INSTRUCTIONS: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Alternate Core Clinical Quality Measure selected by a provider during attestation. The statistical data: Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.

Please note that Exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable)	5
	10
	10

Section 3.3: Additional CQMs						
Alternate Core Meaningful Use Measure	**Average**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unduplicated providers who selected**	
ACQM 1 - NQF 0001 Asthma Assessment	**0.120498662**	**0.302023175**			**46**	
ACQM 2 - NQF 0002 Appropriate Testing for Children with Pharyngitis	**0.585729712**	**0.406688604**			**21**	
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 1	NULL	NULL			5	
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 2	NULL	NULL			5	
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 1	0.061538462	NULL			5	**# of providers who entered 0 in the denominator**
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 2	**0.456140351**	**NULL**			**5**	**5**
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 1	**0.061538462**	**NULL**			**5**	**6**

ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 2	0.456140351	NULL			5	5
ACQM 4 - NQF 0012 Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	0.502232143	0.411901429			4	5
ACQM 5 - NQF 0014 Prenatal Care: Anti-D Immune Globulin						4
ACQM 6 - NQF 0018 Controlling High Blood Pressure	0.320047858	0.122798513			10	**4**
ACQM 7 - NQF 0027 a Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit	0.182492687	0.261817039			12	**4**
ACQM 7 - NQF 0027 b Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies	0.02053343	0.033124912			12	4
ACQM 8 - NQF 0031 Breast Cancer Screening	0.368818079	0.319604938			32	
ACQM 9 - NQF 0032 Cervical Cancer Screening	0.535007248	0.382566349			35	
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 1	0.235524891	0.147532898			8	2
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 2	0.197273434	0.16950897			8	
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 3	0.134782652	0.154589043			8	
ACQM 11 - NQF 0034 Colorectal Cancer Screening	0.304276771	0.354726865			26	2

ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 1	0.38174159	0.366959594			25	
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 2	0.366884501	0.359739142			25	
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 3	0.377466373	0.363976975			25	
ACQM 13 - NQF 0043 Pneumonia Vaccination Status for Older Adults	0.009038685	0.015464216			11	
ACQM 14 - NQF 0047 Asthma Pharmacologic Therapy	0.712515579	0.308533021			26	2
ACQM 15 - NQF 0052 Low Back Pain: Use of Imaging Studies	1	NULL			1	2
ACQM 16 - NQF 0055 Diabetes: Eye Exam						2
ACQM 17 - NQF 0056 Diabetes: Foot Exam						2
ACQM 18 - NQF 0059 Diabetes: Hemoglobin A1c Poor Control	0.111506989	0.167020624			32	2
ACQM 19 - NQF 0061 Diabetes: Blood Pressure Management	0.537103701	0.25944063			25	1
ACQM 20 - NQF 0062 Diabetes: Urine Screening	0.212285903	0.141695317			4	
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1	0.160180039	0.168403539			24	
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2	0.180610567	0.229884441			24	

ACQM 22 - NQF 0067 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD						11
ACQM 23 - NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic						9
ACQM 24 - NQF 0070 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)						
ACQM 25 - NQF 0073 Ischemic Vascular Disease (IVD): Blood Pressure Management						7
ACQM 26 - NQF 0074 Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol						8
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 1						
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 2						
ACQM 28 - NQF 0081 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)						
ACQM 29 - NQF 0083 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular						

Systolic Dysfunction (LVSD)						
ACQM 30 - NQF 0084 Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation						
ACQM 31 - NQF 0086 Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation						
ACQM 32 - NQF 0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy						
ACQM 33 - NQF 0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care						
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1	0.594202899	0.102479244			2	
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2	0.097826087	0.138346979			2	
ACQM 35 - NQF 0385 Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients						
ACQM 36 - NQF 0387 Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast						

Cancer						
ACQM 37 - NQF 0389 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients						
ACQM 38 - NQF 0575 Diabetes: Hemoglobin A1c Control (<8.0%)	0.124981158	0.193722683			11	

Meaningful Use HIE Capabilities

Consistent with and building on the PIN released on July 6, 2010 (#ONC-HIE-PIN-001), the state monitors and tracks key Meaningful Use HIE capabilities in the state. The following table provides current information.

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
1. % of pharmacies participating in e-prescribing	91.4%	93%	94%	96%		
2. % of labs sending electronic lab results to providers in a structured format 1	50%	55%	53.2%	55.5%		
3. % of labs sending electronic lab results to providers using LOINC	36%	40%	40.3%	42.5%		

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
4. % of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	39.2%	44%	41%	44%		
5. % of ambulatory providers electronically sharing care summaries with other providers	14.5%	18%	2.14%	20%		
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC and SNOMED. Yes/no or %	Yes	Yes	Yes	Yes		
7. Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code.	Yes	Yes	Yes	Yes		

Program Priority	Report in first SOP update		Report January, 2013		Report January, 2014	
	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
Yes/no or %						
8. Public Health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide). Yes/no or %	No	Yes	No	Yes		
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1. Yes/no or %	No	Yes	No	Yes		

Section 5: Project Management Plan

Scope of Effort

Alabama's Phase 1 to Phase 2 Plan was previously provided to ONC and provided in Appendix A. The Phase 1 to Phase 2 Plan provides the project plan for One Health Record®, including the five core ONC domains: (1) governance, (2) technical infrastructure, (3) technical and business operations, (4) policy and legal elements and (5) finance.

Direct: That state has taken specific actions to increase the implementation of DIRECT through activities such as working with mental health providers, community hospitals that are intake facilities for individuals with mental health issues, increased webinar training on the utilization of DIRECT and entering into a contract with AL-REC for meaningful use and DIRECT technical assistance. In addition, Alabama is expanding the HISP to HISP connections with their state partners in the southeast region for interstate PHI exchange. The state is also looking at increasing participation by health home providers through case management strategies.

Stakeholder Engagement: A face-to-face One Health Record® Commission meeting is being planned. The A-HIE outreach activities are being redesigned with the focus on face-to-face EP engagement that illustrates the benefits of utilizing One Health Record® in care coordination. The co-chairs continue to be the Commissioner of Public Health and the Acting Commissioner of Medicaid.

One Health Record® Activity Schedule

Project Plan	Estimated Start Date	Estimated Finish Date
Alabama One Health Record® Implementation Analysis and Design	8/1/2011	Completed
Core System Development	8/1/2011	Completed
Remote Connectivity	09/6/2011	Completed
Data Loading: Medicaid	12/5/2011	Completed
Data Loading: Public Health	12/5/2011	In Process
Data Loading: CHIP	12/5/2011	Completed
Core System Availability	1/30/2012	Completed
Phase 1 Integration	10/17/2011	Completed
Phase 1 Load	4/1/2012	Completed
Phase 1 Go Live of Pilots	3/12/2012	Completed
Engage all the providers doing case management in the Medicaid Health Home	2/1/2013	Ongoing

Project Plan	Estimated Start Date	Estimated Finish Date
Networks to use DIRECT as their means of communication for referrals and case summaries through use of train the trainer.		
Engage community mental health centers to use DIRECT to send PHI to their intake facilities.	2/1/2013	Ongoing
Connecting One Health Record HISP to West Virginia, GA and South Carolina.	10/1/2012	In Process
Phase 2	5/2/2013	02/28/2014
Ongoing Stakeholder Involvement for Phase 2	5/2/2013	02/28/2014
Transfer of Governance (If determined to do so): Seek Legislative Authority and sign Agreements for Transition to Long-Term Sustainability	TBD	2015
Ongoing Coordination with Other Programs and Grantees during Phase 2	5/2/2013	2/28/2014
Ongoing Operations of Medicaid Incentive Program for AUI, Stage 1 and Stage 2	Ongoing	2021
Continued Review of Privacy and Security Issues related to any changes in the HIPAA legislation or rule	Ongoing	Ongoing
Outreach and Enrollment of Additional One Health Record® Participants	6/1/2013	Ongoing
Connectivity Grants	5/1/2013	In Process
HIT-HIE I-APDU for Medicaid "Fair Share" for Technical and	Post-ONC Grant	Post-ONC Grant
Finalize Finance and Business Model for Sustainable HIE	Fall 2013	Early 2014
Evaluation: Final Report	5/1/2013	March 2014
Alabama One Health Record® Ongoing Operations	Upon Completion of Phase In of Services and Geographic Locations	TBD

Alabama HIE Business Plan Development Action Items, Deliverables and Current Risks and Mitigation

Tables addressing each of these items are provided in the Phase 1 to Phase 2 Plan, approved by ONC in May 2013, and provided in Appendix A.

Alabama Staffing Plan

Tables addressing the staffing plan and related budgetary impact are provided in the ONC approved Phase 1 to Phase 2 Plan provided in Appendix A.

In addition, Alabama has submitted an HIT-I-APDU which includes staffing and administrative functioning support (travel, computers, space, supplies, telephones, etc.) and contract support for the Meaningful Use EHR Incentive Program and One Health Record® activities under the HIE "Fair Share" funding.

Total approved funding for A-SMA's state resources associated with HIE "Fair Share" funding as previously approved by CMS on July 25, 2012, is $587,369 with the federal share at $528,632 and state share at $58,737. One Health Record® A-HIE approved funded activity includes A-SMA staff (project director, administrative manager and clinical IT analyst), and operational and administration expense. The Truven Healthcare, (formerly Thomas-Reuters Healthcare) technical vendor connectivity to the MMIS contract, has been removed and Medicaid funding will not be used for the interface with the MMIS. ONC funding will be solely used.

Staff Additions:

- The A-SMA has determined that it requires additional staffing for the review and approval of Provider applications/attestations for EHR incentive payments. The ASMA negotiated a contract amendment with its SLR vendor effective February 2013 to provide, at ASMA's discretion, dedicated vendor support staff to assist the A-SMA in reviewing and evaluating provider attestations in accordance with Alabama policy and procedures. All final attestation approvals and approvals for payment will remain with A-SMA State staff. -

- The A-SMA requested an additional position to perform the accounting and reporting duties. To date, Alabama has issued over $75,000,000.00 in incentives and expended over $2.5 million in administrative funding and has a statutory and regulatory responsibility to ensure that all federal and state funds are accurately issued, tracked, monitored and reported. As the program funding increases over multiple years; this task multiplies in complexity and requires dedicated staffing. Allowing this position to focus on financial tracking and reporting will assure improved federal and state financial and reporting compliance.

- The State requested funding for one-half FTE to oversee a vendor to perform the post-payment audit function. The selection of a vendor to perform the post-payment audit function is a change from original program planning wherein the State intended to conduct audit activities with in-house State staff. The State has since determined that this activity cannot be accomplished with State staff and must be contracted out.

- A-SMA requested state staff and contracted personnel support the development of the governance, financial, business and technical operations, technical architecture, and policy/legal structure for One Health Record®. ASMA staffs the strategic and

operational planning of One Health Record®, which "went live" April 2012. State staff includes the project director, administrative manager and clinical IT analyst.

- A-SMA requested contract support through George Washington University (policy and federal compliance consulting) and USA (HIT Coordinator responsible for oversight of the objectives of the ONC Strategic and Operational Plans (A-S/OPs), particularly governance and finance) specifically related to One Health Record®.

- A-SMA requested ongoing support for educational and engagement communications and materials development and dissemination about the EHR Incentive Program and/or EHR Adoption/meaningful use.

- A-SMA requested ongoing technical support for environmental scans, gap analyses; provider needs assessments and multi-state collaborative efforts related to MU.

Meaningful Use State Personnel Resource Statement

State Staff Title	% of Time	Project Hours	Annual Cost with Benefits	Description of Responsibilities
HIT Director	50%	1040	$59,958.00	Oversees the Meaningful Use and One Health Record® Programs : 50% One Health Record® and 50% MU $119,915/yr. at 50% time = $59,957.5 (rounded $59,958)
Meaningful Use Program Manager	100%	2080	$77,051.00	Coordinates all efforts set forth by CMS for the implementation and adoption of meaningful use criteria by EPs/EHs in the Medicaid system.
MU Analysts (3 Positions)	100%	6240	$186,684.00	Coordinates the review, evaluation, and action taken on EHR incentive payment applications. $60,172/yr. x 2 positions = $120,344 $66,340/yr. at 1 position = $ 66,340 Total = $186,684

State Staff Title	% of Time	Project Hours	Annual Cost with Benefits	Description of Responsibilities
Meaningful Use Reporting/ Accounting Analyst:	50%	1040	$30,086.00	Coordinates the multiple reporting and accounting requirements that must be met through the various funding sources. This position is currently vacant and remains unfilled due to state budget constraints. The duties have been distributed among existing staff until the position is filled. $60,172.00/ yr. at 50% time = $30,086
Meaningful Use Administrative Support:	100%	2080	$35,477.00	Provides clerical support to the HIT Division and coordinates and tracks the various work of other HIT staff members.
Meaningful Use Program Integrity Coordinator	50%	1040	$30,086.00	Staff to manage the Program Integrity contract and coordinate activities between the PI Division and the HIT Division $60,172.00/ yr. at 50% time = $30,086

One Health Record® State Personnel Resource Statement

State Staff Title	% of Time	Project Hours	Annual Cost with Benefits	Description of Responsibilities
One Health Record® Project Director	50%	1040	$29,979	Oversees the Meaningful Use and One Health Record® Programs : 50% One Health Record® and 50% MU One Health Record® time: 50% ONC funded & 50% Medicaid Direct the design, development and implementation of One Health Record®, including policy/legal, technical architecture, governance, finance, and technical and business operations. $119,915/yr. at 50% time = $59,957.5 (rounded $59,958) $59,958 at 50% funding = $29,979

State Staff Title	% of Time	Project Hours	Annual Cost with Benefits	Description of Responsibilities
One Health Record® Clinical IT Analyst	100%	2080	$38,525	Provides system administration support regarding HIE operations and EHR integration. One Health Record® time: 50% ONC funded & 50% Medicaid $77,050/yr. at 50% funding - $38,525
Administrative Manager	100%	2080	$30,386	Administrative support, including coordination and tracking of the various work flow, documents, and budget One Health Record® time: 50% ONC funded & 50% Medicaid $60,772/yr. at 50% funding = $30,386

Combined Meaningful Use & One Health Record® State Personnel Resource Statement

State Staff Title	Project Hours	Annual Cost with Benefits
State Staff Grand Total	**18,720**	**$518,232**

Meaningful Use Contractor Personnel Resource Statement

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities
Xerox/ ACS (See Note [1] Below)	$450,000.00	$450,000.00	$900,000.00	***Purpose:*** Ongoing Operations Support for the Alabama State Level Registry. See Notes below regarding contract amount, period and term. ***Contract Expires:*** 01/31/2013 with options to renew annually through 2016.

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities
	$229,000.00	$343,000.00	$572,000.00	***Purpose:*** Proposed amendment to existing contract to provide additional State Level Registry staffing support to perform attestation activities. ***Contract Expires:*** Proposed effective date of the Amendment is 2/1/2013, the expiration date coincides with existing contract expiration date of 1/31/2016 and existing renewal options
FourThought Group (See Note [1] Below)	$295,176.000	$295,176.00	$590,352.00	***Purpose:*** Overall program support for MU program including program, policy and procedure development; support and oversight of the design, development and implementation of the SLR; and operational support for distribution of incentives. All travel and expenses are included. Initial Contract Expires: 9/30/2012 with
George Washington University (See Note [3] Below)	$142,500.00	$142,500.00	$285,000.00	***Purpose:*** Provide technical assistance, identify policy issues, strategize options and act as a Subject Matter Expert (SME). All travel and expenses are included. (Figure represents 50% of $285,000 Contract attributed to Meaningful Use.) ***Contract Expires:*** 2/28/2013 with options to renew annually through 2015.

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities
University of South Alabama	$123,363.00	$123,363.00	$246,726.00	***Purpose:*** Contract represents the agreement with the University of South Alabama (USA) for the cost of its employee serving as the HIT Coordinator and the related travel expenses. (Figure represents 50% of $246,726 Contract Amount attributed to Meaningful Use and 50% ONC.) ***Contract Expires:*** 08/08/2013
	$675,000.00	$675.000.00	$1,350,000.00	***Purpose:*** ***for Alabama REC*** Contract to provide through Alabama REC program support, including outreach/education to Providers in underserved communities of Alabama to encourage Meaningful Use of EHRs. Program support to provide technical assistance to providers throughout the state with the enrollment and administrative processes as well as technical requirements for the Health Information Exchange – co-located at the Networks ***Contract:*** To be developed.
	$311,716.00	$311,716.00	$623,432.00	***Purpose:*** Medical Informatics services that includes systems development, population modeling, analytics and reporting. ***Contract Expires:*** 9/30/2016

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities
Tuskegee University	$1,000,000.00	$1,000,000.00	$2,000,000.00	***Purpose:*** MOU to provide program support, including outreach/education to Providers in underserved communities of Alabama to encourage Meaningful Use of EHRs. ***Contract Expires:*** 10/31/2013 and may be extended at the State's discretion within existing total contract amount.
Alabama State University	$1,000,000.00	$1,000,000.00	$2,000,000.00	***Purpose:*** MOU to provide program support, including outreach/education to Providers in underserved communities of Alabama to encourage Meaningful Use of EHRs. ***Contract Expires:*** 06/31/2013 and may be extended at the State's discretion within existing total contract amount.
TBD - Auditing	$650,000.00	$450,000.00	$1,100,000.00	The State is preparing an RFP to secure the services of a contractor to produce a Meaningful Use detailed Audit Plan as well as conduct post-payment audits.
MU Contract One Year Total	**$4,876,755**	**$4,790,755**		

One Health Record® HIE Contractor Personnel Resource Statement

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities

Contractor	FFY 2013 Contract Costs	FFY 2014 Contract Costs	2 Year Contract Costs	Description of Responsibilities
GWU	$71,250.00	$71,250.00	$142,500.00	50% of $285,000 Contract attributed to One Health Record® = $142,500. 50% of the $142,500 is Medicaid and 50% is ONC funded for the completion and updating of the SMHP and the HIT--IAPDU, providing TA, identifying policy issues, strategize options and acting as a SME. All travel and expenses are included.
University of South Alabama	$61,682.00	$61,682.00	$123,364.00	50% of Contract Cost ($246,726) attributed to One Health Record® = $123,363, 50% of the $123,364 is Medicaid and 50% is ONC funded = $61,682 Medicaid and $61,681 ONC. University of South Alabama contract represents the agreement with USA for 75% of costs of the HIT Coordinator, travel expenses and an administrative assistant.
One Health Record® Contract One Year Total	**$132,932.00**	**$132,932.00**		

Combined Meaningful Use & One Health Record® Contractor Personnel Resource Statement

Total Contractor Staff Costs	FFY 2013 Costs	FFY 2014 Costs
Contractor Grand Total	**$5,009,687**	**$4,923,687**